SAQI
The South African Quality Institute

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In this month's Newsletter

In this month's newsletter we are asking the question **"How seriously do we address risk and what is risk assessment?"**

At the end of August, SAQI had the opportunity to address the annual Copicon congress entitled "Critical 4 Africa". This congress addressed major issues in the Critical Care field in the medical sector, not only in this country but around the world.

Some disturbing facts emerged from the various speakers at the conference but what we need to highlight is "What are the risks and what can be done to mitigate them?"

One of the presenters indicated how safe it is to fly on a commercial aircraft. There is only one "Hull loss" (that means a total wipe out of passengers) per 10 million USA commercial airline take offs (source IATA). He then compared this with the one in ten people worldwide receiving healthcare treatment that will suffer preventable harm (source WHO). If we combine these figures he indicated that there is a million times greater chance of incurring harm in a hospital than on an American commercial airliner. Now whilst these statistics are disturbing it was good to see at the congress that the medical profession itself was recognising these issues and are actively putting together plans to rectify this situation.

When it comes to managing risk the nuclear industry is on a par with the airline industry but again we mustn't become complacent. The Fukushima incident of last year was a wake up call on how we cannot take nuclear safety for granted. Our regular contributor Paul Naysmith addresses this issue.

In our "Benefit of Hindsight" series in this issue we reflect on a speech made by the late Dr. Joseph Juran in 2002 where he addresses the issue of Quality in Leadership.

We always welcome your comments relating to our newsletters.

Yours in Quality

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PROUDLY SOUTH AFRICAN

What is a Risk Assessment?

Or How the Fukushima disaster could have been prevented, by Paul Naysmith

On the Friday afternoon of the eleventh of March 2011, an earthquake of a magnitude of 9.0 was detected approximately forty five miles off the coast of Japan. Not long after this, it was declared, that this was one of the most powerful earthquakes in recorded history. The earthquake set off a chain of events, which included a hundred and thirty feet tall tidal wave (ironically this is the same height as the world's tallest water slide in Brazil), travelling powerfully at seventy miles an hour, that spanned four miles in-land. An earthquake so mighty, that it moved an eighty eight thousand square mile island, of Honshu, eight feet to the east. To this day, substantial debris, like a Harley Davidson motorcycle, is being washed up on the western shores of Canada and the United States of America. The World Bank put this as one of the most expensive natural disasters of all time, perhaps not quite as expensive as the estimated sixteen thousand people who lost their lives.

All of these facts will be long and forgotten, and most in our society, will associate this earthquake with the Fukushima nuclear power station disaster.

After a year of hard work containing the various issues on-site at the nuclear plant, the report was released to the world. As I began reading the report, the investigation Chairman asks "How could such an accident occur in Japan, a nation that takes such great pride in its global reputation for excellence in engineering and technology?" this is a very powerful question to ask. I am now asking myself, why I am reading this report.

For many years I've always been fascinated by reports, I'm lucky to get to write them as part of my work, however I look to these, and any investigation report from other industries, as a learning opportunity. Why did the failure occur? What is going to change to prevent a similar repeat failure? How can the company I work for, benefit from me reading this report? All the questions I think to myself when picking up the many pages. Perhaps you are not like me (I really do hope so) and choose to spend your time constructively avoiding to read reports in your spare time, but I feel that I need to share what I learned with you, from this investigation.

I'm not sure if you have the luxury of being involved or reviewing your internal company investigation reports to failures. I would like to think that you have and are familiar with an investigation process that would require your company to aim to get to the root cause of the issue. I would go as far to presume that you may use or have read techniques, such as the 5 why's, to help you there.

Let me jump to the end of the six month investigation, where the root cause lies: "Therefore, we conclude that the accident was clearly "manmade.""[1] Ok, I struggled with this, a mega wave that overcomes the thirteen foot sea defense at the nuclear plant, an earthquake in an instant erases buildings and the necessary access to the site, was somehow "manmade"

"What's going on?" I'm thinking. Really was it "manmade", it's been a while from my studies into the Greek classics. Poseidon, I remember, was the God of all the seas, and not a man. I got to read on to find out more behind this statement.

"The operator, the regulatory bodies and the government body promoting the nuclear power industry, all failed to correctly develop the most basic safety requirements—such as assessing the probability of damage, preparing for containing collateral damage from such a disaster, and developing evacuation plans for the public in the case of a serious radiation release." Now I see it, the manmade element is coming from the "assessment of the disaster".

The report continues "In addition, although the Nuclear Safety Agency and the operators were aware of the risk of core damage from tsunami, no regulations were created, nor did the operator

take any protective steps against such an occurrence. Since 2006, the regulators and operator were aware of the risk that a total outage of electricity at the Fukushima Daiichi plant might occur if a tsunami were to reach the level of the site. They were also aware of the risk of reactor core damage from the loss of seawater pumps in the case of a tsunami larger than assumed in the Japan Society of Civil Engineers estimation. The regulatory bodies knew that the operator had not prepared any measures to lessen or eliminate the risk, but failed to provide specific instructions to remedy the situation."

So, in summary, this manmade disaster was a failure in the Risk Assessment process, which I presume was created by man. So this manmade disaster is all down to this thing called a 'risk assessment'. If not familiar with risk assessments, I suggest you quickly master this Quality improvement technique. As it is a powerful prevention tool for you to use. However I want to advise you on judging a good risk assessment, from a poor one.

Ok here I go, time to apply my super hero Quality Punk skills of over simplification on providing a definition of a 'risk assessment': a risk assessment is an assessment of risk. Got you! No it's not that simple; however I wanted to reel you in. By the way, should anyone choose to define something by rearranging the words into a new order, to me that usually means that they don't actually know what they are talking about? Or you may find the person that chooses the other bluffing practice of constantly repeating the same term, in order to fool you into thinking that they know what they are talking about. Reminds of a time when I interviewed someone and asked them to define a 'process'. Only for the interviewee to say the word "process" over twenty times in their response. I lost count at twenty, I had to make an intervention to prevent from myself from passing out with boredom.

So if you are familiar with your safety risk assessment, this is known as a "Quantitative Risk Assessment", I'll use this to explain risk assessments. Here the risk (R) is calculated from two elements: the impact of the loss (I) and the probability that it will happen (P). Most Government Health and Safety agencies will have their own defined process, or matrix, for example in the UK (http://www.hse.gov.uk/risk/) the Health and Safety Executive, will even give you templates for free.

The risk assessment process will take the participants through a set of assumptions and uncertainties, which are all considered through a brainstorming type exercise. The risk will be calculated from the impact value, multiplied by the probability. Or in mathematical terms: $R = I \times P$. So for example the risk of being run over when crossing the road in Manhattan Island, New York city, during rush hour, the impact could be very high (being run over by a car), however the probability could be very low (cars don't move very fast during rush hour). However knowing that there is a terrible outcome, we come to the most important part of the Risk Assessment: mitigating the risks. So in Manhattan, to reduce the risk of being run over, the city provides safe crossing zones, or even making a physical separation between the pedestrians from the traffic.

For Fukushima, Chairman Kurokawa is very damning on the "mindset" that did not address the mitigating actions to the known risks. Interestingly his report looks beyond the regulators, the operator, but to Japan as a society: "The consequences of negligence at Fukushima stand out as catastrophic, but the mindset that supported it can be found across Japan. In recognizing that fact, each of us should reflect on our responsibility as individuals in a democratic society." They as a nation failed to address the actions required to mitigate the risk. I find that this is often forgotten, addressing the mitigating actions. However it is always the most crucial part of the Risk Assessment process.

Please don't become comforted into thinking that a Risk Assessment is complete when all sections of the form are filled in, it is certainly not yet finished. It is only finished when you have put in the preventive measures in place, and tested them for efficacy. This is where the Fukushima event started, not at the time of the earthquake or tidal wave, but at the exact point of inaction. This is the difference between a good risk assessment and a poor one: following through with the identified actions.

Like many other disasters (Space Shuttle Challenger, Chernobyl, or Costa Concordia) I'm sure this major event at Fukushima this will shake the being of all that were directly involved. For me I think of all these terrible events, not for the known failings or awful headlines, but what we as society have to do to prevent them from happening again. It is clear to me, the "manmade" error led to the failing of the safety systems at the nuclear plant at Fukushima, was in the failure to address the known risks and implement the prevention measures.

So the next time you have little management support to implementing your mitigating actions from a risk assessment, remind yourself to recognize that was the same mindset that created Fukushima. Preventing an issue from happening is much more comfortable feeling, than having to explain why you did nothing to stop it from happening.

[1]The National Diet of Japan, The official report of The Fukushima Nuclear Accident Independent Investigation Commission Executive summary

About the Author

Paul Naysmith as well as being a Quality Punk and Improvement Ninja, is the HSEQ region manager in the United States for a leading oil and gas well services company. He is a Chartered Quality Professional with the UK's Chartered Quality Institute (CQI) and an honorary member of the SAQI. Naysmith has a bachelor of science in paper science and management, has worked in industrial textiles, food manufacturing, and the aerospace industry. When not working, he enjoys photography, training to become a Cajun, and spending every precious moment with his family.

Paul is appointed as a regular contributor to the eQuality Edge. Reproduction of any of Paul's articles can only be authorised by contacting him directly at naysmith@yahoo.com

With the benefit of hindsight

This is the second in the series of looking back at articles published more than 10 ago and questioning if the comments are still relevant today.

Speech on Quality in Leadership

MINNEAPOLIS, 26 JUNE 2002
By the late Dr. Joseph M. Juran, Chairman Emeritus, Juran Institute, Inc.

"Managing for quality grew enormously in importance during the 20th century. That growth has already impacted our economy considerably. Managing for quality has become a major element of competition, nationally and internationally." - Joseph Juran

Thank you for inviting me to this historic event. To my recollection yours is the most serious initiative ever undertaken to bring the U.S. to a position of world leadership in quality.

In my remarks I will address several issues that are pertinent to leadership in quality.

My first point is rather obvious.

Leadership in Quality is Attainable

We know that leadership in quality is attainable because some companies have already attained it. In Japan, enough companies have done so to bring that country to a state of world leadership in quality. Yet this was a country whose pre-World War II reputation was as a producer of shoddy exports.

Here in the U.S. we also have companies who became the acknowledged quality leaders in their industries, but those companies are relatively few in number. The great majority of our companies have yet to reach such a state. Our broad challenge is to bring all companies up to the level of the best.
Next, let me note that…

It Takes Years to Attain Leadership

I have estimated that by the mid-1970s the Japanese had become competitive in quality with the West. A decade later they had become generally acknowledged as world leaders. That suggests that it took them about 35 years, starting with one of the worst quality reputations. Yet their persistence paid off—their stunning performance in quality was the major reason for their becoming an economic superpower.

The U.S. quality leaders started with better quality reputations—they were generally competitive in their respective industries. Yet I know of none who took less than six years to become leaders; more usually it took closer to ten years.

Why did it take so long? The chief reason is that most of the time was lost in exploring roads that led nowhere—l*earning what not to do*.

One of our challenges is to provide the lagging companies with reliable information on which were the roads that led nowhere and which led to quality leadership. An example of such information is the presentations made by the Baldridge Award winners at the conferences organized by NIST—the National Institute for Standards and Technology.

Next let me point out…

We Know the Success Factors

I have studied the strategies used by the quality leaders, Japanese as well as those in the U.S. I found that there was much commonality. The most frequent strategies included the following:
- The chief executives personally led the quality initiative.
- They trained the entire managerial hierarchy in managing for quality.
- They enlarged the business plan to include strategic quality goals.
- The goals included improving quality at a revolutionary rate, year after year.
- They set up means to measure progress against the quality goals.
- The senior managers reviewed progress regularly.
- They provided for participation by the work force.
- They enlarged the system of recognition for superior performance in quality.

Let me here exemplify by way of the quality improvement process.

The Quality Improvement Process

Many of my early consulting engagements involved improving quality by improving the yields of manufacturing processes. Each company confided to me at the outset that "Our business is different." From their perspective they were right; each did

exhibit differences as to products, markets, technology, culture, and so on. Yet their quality problem exhibited commonality. To diagnose those problems I employed common diagnostic tools. To provide remedies I employed common remedial concepts and tools. To hold the gains I employed common control concepts and tools. As I moved from one "different" company to another, I was going through the same cycle of events, over and over. The concepts, methods, and tools I used turned out to be applicable to any company.

I was intrigued by the existence of those commonalities, and I gradually identified the elements of that common cycle of events. In 1964 I devoted half of my book "Managerial Breakthrough" to the universal process for improving quality (or improving anything else). I then continued to refine that process, which became an integral part of my training manuals on managing for quality.

By the year 1964 I had unbounded confidence in the validity of that universal approach. I had field-tested it in many client companies; it had repeatedly produced stunning results. I had witnessed the miracles and had thereby acquired the faith of the true believer.

We lack the time for me to go into the specifics of the quality improvement process. I must refer you to Chapter Five of Juran's Quality Handbook, Fifth Edition, McGraw-Hill, 1999. It uses 73 pages to set out the details.

Before leaving the quality improvement process, let me add some pertinent comments:
• Annual quality improvement is one of the essential success factors; without it there can be no quality leadership.
• It is a big advantage for companies to have available a field-tested, proven managerial process as an aid to annual quality improvement.
• Training is needed to enable company personnel to attain mastery of the quality improvement process.
• The training should include participating in actual improvement projects.

Next, let me note that some additional universal managerial processes have been evolved and field-tested. Two of the more important are quality planning and quality control.

The Quality Planning Process

Figure One is a simplified input-output diagram showing the universal quality planning process as it progresses step-by-step.
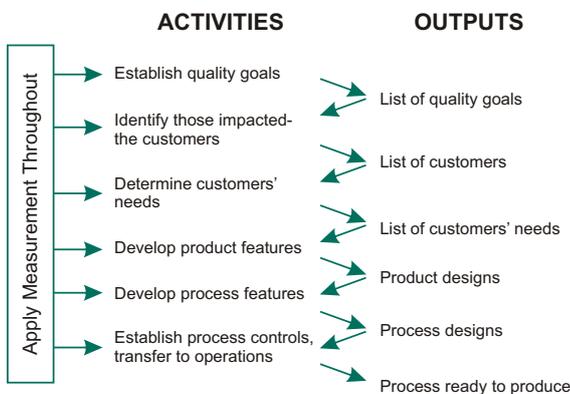

Figure One, The Quality Planning Road Map

There are many versions of this process in the quality manuals of companies. A highly, detailed version is available in Juran's Quality Handbook, Fifth Edition, pages 3.1-3.50.

The Quality Control Process

The quality control process exists to prevent adverse change. It is based on the universal feedback loop (Figure Two).
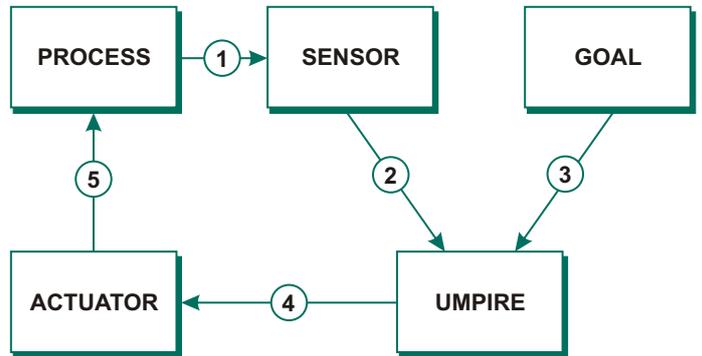

Figure Two, The Feedback Loop

A detailed explanation is in the Handbook, pages 4.1-4.29.

Those three processes are interrelated, as shown in the Juran Trilogy Diagram, Figure Three.
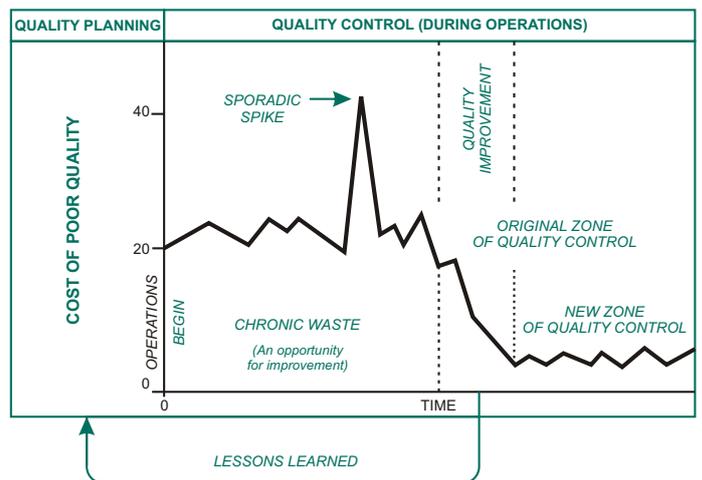

Figure Three, Interrelation of Planning, Improvement, and Control (The Juran Trilogy® Diagram)

Beyond those managerial processes there is now available an extensive array of universal concepts, methods, and tools to help companies in their efforts to attain quality leadership.

That brings me to a logical and pertinent question…

Why Don't Our Companies Just Do It?

Given all that available know-how, why don't our companies make use of it to become quality leaders? We know some of the reasons:
• They are sceptical; many have tried and failed.
• They have learned not to trust the advocates, internal as well as external. They don't know whom to trust; there are many advocates and agendas.
• They cling to the mistaken belief that "Our business is different."

- They believe that getting certified to ISO 9000 will solve their quality problems.
- The fact that mediocre quality is still saleable.
- The confusion in language—the belief that "higher quality costs more."
- The belief of the CEO that he can lead the company to quality leadership without personally becoming deeply involved.

While these and other reasons are all present, we really don't know which reasons dominate; we lack solid researches in this area. I respectfully suggest that such researches are in order.

So We Are At an Impasse

Meanwhile we are at an impasse. We know that quality leadership is attainable. We know which are the success factors and the managerial processes that have led to quality leadership. We have indications of the order of magnitude of the potential gains. Despite this array of knowledge, the bulk of our companies are not rushing to make use of it.

The challenge facing us is how to break that impasse.

Here I venture to offer a proposal that stems from the existence of the Executive Advisor Board that is sponsoring this conference. The Board is composed of senior executives from leading institutions in industry and academia. Its mission is strictly pro bono publico. To my knowledge, such a mission, undertaken by so distinguished an array of high executives, is without precedent in the history of managing for quality. Such a mission confers a high degree of credibility, and that credibility opens the way for breaking the impasse.

A Proposal for Research

My proposal envisions a sizeable research to serve as the basis for a manifesto—a public declaration by the Board—setting out the results inherent in quality leadership, and the proven roads for getting there.

If we know all the things I set out earlier in my remarks, then why do we need a sizeable research? My reason is that some of the things we know may not be so. In any event, the Board's declaration should, in my view, not be based solely on assertions and claims by company managers and advocates like myself; they should be verified by independent research.

The research I envision would require teams to visit a sample of companies who had launched quality initiatives during the 1980s and 1990s. The visiting teams would reconstruct what had taken place and why. They would also evaluate the results achieved, along with the impact on the company cultures. The findings from those field studies would then be analyzed to draw the conclusions that would appear in the public declaration.

Such a research would likely consume two to three years of calendar time and would require financing of several million dollars. Such financing should come solely from *pro bono* sources such as non-profit foundations.

An example of such a research was the National Demonstration Project on Quality Improvement in Health Care. Its mission was to answer the question: Can the tools of modern quality improvement, with which other industries have achieved breakthroughs in performance, help in health care as well? That project was financed by the John A. Hartford Foundation. The findings were published in the book, "Curing Health Care" by Berwick, Godfrey, and Roessner.

Contributions of the Media

I confess disappointment at the limited contribution made by our media during the massive changes undergone during the 20th century. With rare exceptions they failed to recognize the major quality events of that century: the Japanese quality revolution; the associated emergence of Japan as an economic superpower; the creation of the Baldridge Award (in Japan the award of the Deming prizes is shown on national television); the fact that market shares of the Baldridge winners greatly outperform the Dow Jones industrial averages. Similarly, the media failed to analyze the significance of such initiatives as the ISO 9000 series of standards or the more recent Six Sigma phenomenon.

During my years in the field, I have been interviewed by numerous business journalists. The subject of managing for quality was new to many of them, and I was embarrassed to watch them struggle—they had no idea of what questions to ask. There were exceptions—men such as: Jeremy Main of Fortune Magazine, Otis Port of Business Week, and Richard Spiegelberg, Management Editor of the Times of London. The first two had dug in and informed themselves about the subject; they then wrote some memorable articles. Jeremy Main went further. His book "Quality Wars" is a most useful analysis of the quality initiatives taken in many industries. Spiegelberg was a management generalist who was nevertheless fully at ease in the specialty of managing for quality.

In my view, the new importance of managing for quality justifies the designation of a few journalists to become well informed on the subject so that they can provide balanced interpretations to the electorate. There is no lack of such specialists in other fields—finance, sports, science, and so on. The media own the megaphones and thereby have the opportunity to be of great aid to useful initiatives.

The Role of Academia

Managing for quality grew enormously in importance during the 20th century. That growth has already impacted our economy considerably. Managing for quality has become a major element of competition, nationally and internationally. It provides a career path for huge numbers of specialists and managers. (The American Society for Quality has certified over 100,000 specialists in categories such as Quality Engineer.)

Academia took notice of that growth in managing for quality. The Bell Laboratories' invention of so-called "Statistical Quality Control" (SQC) led to the creation of courses in the subject, first by the U.S. Government during World War II and then by various U.S. universities. The leading textbook was by Professor Eugene L. Grant of Stanford University. Later still, some business schools and Industrial Engineering departments began to offer courses in managing for quality as a part of their curriculum. By the 1980s, formal alliances began to spring up between large companies and their favourite business and engineering schools, with a view of enlarging the role of the schools in preparing graduates for careers in managing for quality.

I suspect that during the 21st century, academia will greatly extend its participation in managing for quality. That extension will include creation of degree granting curricula in managing for quality. To present such courses will require teachers who are knowledgeable about the quality problems of industry. The schools will also need to establish close alliances with industry in order to keep up with the changing realities that face the managers.

A by-product of degree-granting curricula is the evolution of a recognized profession, along with national examinations such as are available for the title of Professional Engineer or Certified Public Accountant.

Toward a Science of Managing for Quality

A further role for academia relates to the evolution of *a science* of managing for quality.

Our ancient forebears were quite ingenious in developing ways to meet their quality needs. They invented quality specifications, measurement, warranties, inspection, quality audits, and more. They invented the village marketplace. They invented the concept of dividing work into recognized crafts—farmer, shoemaker, and so on. These were common-sense responses to the needs but they were based largely on empiricism.

The passing centuries then brought massive changes. Villages grew into towns, cities, and nations. Competition grew and intensified. The Industrial Revolution and the factory system did extensive damage to the craft concept. Mass production and distribution brought with them large numbers of field failures along with problems of product safety and damage to the environment.

The response to those massive changes was at first largely empirical, and generally inadequate. The 20th century then witnessed a movement toward a more scientific approach. It began with the adoption of "Statistical Quality Control." The growth of measurement by variables then ushered in the concept of quantified process capability, with resulting great improvement in process planning. The evolution of models for reliability planning has greatly improved our approach to product design. (Amazingly, one of our most complex products, the commercial airplane, has a failure rate—a crash rate—of under one per million flights in the U.S.) The discoveries that there are universal managerial processes for quality planning, control, and improvement—The Trilogy—has been of great aid to industry generally.

During the 20th century academia contributed usefully to research in the field, but most came from **industrial specialists and consultants**.

I expect that during the 21st century, academia will (must) greatly enlarge its contribution.

Editor's comment:

What was said ten years ago by one of the greatest quality gurus of our time still holds true today. We still need more research on quality and the media coverage needs to increase in the promotion of quality initiatives. Leadership is still not always in touch with the reality of daily operations and what quality is really all about.

SAQI would welcome comments on this article from our readers.

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Customer Care

By Monde Mekute, Executive Manager: Quality
Carl Zeiss Optronics (Pty) Ltd

Most organizations are investing heavily in strengthening their customer care functions. This is because a strong customer care function is a valuable asset to the organisation and can help the organization gain a competitive edge over its competitors and strengthen its position in the market place.

The level of customer care reflects the importance the organisation places on customers and their needs. Poor customer care irritates customers and forces them to defect to competitors. The customer care function has an element of public relations to it; every interaction with customers has the potential to either build loyalty or breed dissatisfaction. Good customer care helps create customer loyalty.

The primary goal of customer care is to retain customers and create customer loyalty through constant pursuit to satisfy and delight them. The customer care function ensures that customers are ecstatic enough to pass positive feedback about your business to others who may then try your products or services for themselves and in turn become repeat customers as well. These word-of-mouth referrals significantly contribute to customer acquisition.

Customer care starts with helping the customer make wise purchasing decisions, and then handles all technical and commercial issues with the purchase. It is the interface between the customer and the organization - front end function, and it is the custodian of the customer relationship management (CRM).

Food for Thought

(1) Only a fool tries to fill a bucket of water when the bucket has lots of holes; better to fix the holes and stop the leaks before you try to fill the bucket.

(2) It takes far less of an investment to keep a customer than to gain a new one. Typically it costs about 5 times more to acquire new customers than retaining current customers.

(3) If you are a good salesperson; you can sell almost anything to anyone. It will however be your approach to customer care that determines whether or not you will ever be able to sell that person anything else again.

(4) Over time good customer care will bring in more new customers than promotions and price slashing do.

(5) If you aren't taking care of your customers; your competition will.

(6) Customers share their experiences with others. Having a complaint effectively and efficiently resolved causes most customers to recommend the supplier to friends and about 80% of customers tell someone if their complaint is not handled well.

The six points above illustrate the importance of thinking of customer care as an investment; not simply a cost. It is the lifeblood of any business and vital for business success and sustainability.

Characteristics of Good Customer Care

(1) Deal effectively and efficiently with complaints – this is the essence of the customer care function. Be helpful even if there is no immediate profit in it. Follow up and go the extra mile.

(2) The front-end customer care personnel deal directly with the most important person in the organization — the customer. This therefore means that a lot of focus and resources should be invested into strengthening this function.

(3) Rude behaviour and incorrect information annoy customers. Always avoid arguments with customers. Customer Care personnel should be trained and updated on regular basis. This keeps them updated on the latest products and service

upgrades. This enables them to provide accurate information to customers and also boosts their confidence & morale levels.

(4) Make sure that Customer Care personnel are easily available to customers. Ensure that customers are not transferred from one person to another, but are able to speak to the right person soon after dialling the customer care number. If getting hold of the customer care personnel requires significant effort, customers will be annoyed and defect to competitors. Most importantly, customers want to speak to a human being, not a fake recorded robot. Not listening to the customer and giving standard replies that do not address a customer's problem makes the whole customer care a futile exercise.

(5) Promise what you intend to deliver; or don't promise at all. Customers will lose trust in the organization if they receive promises from customer care personnel that go unfulfilled. Reliability is the key to any good relationship. There is nothing more annoying to customers than broken promises.
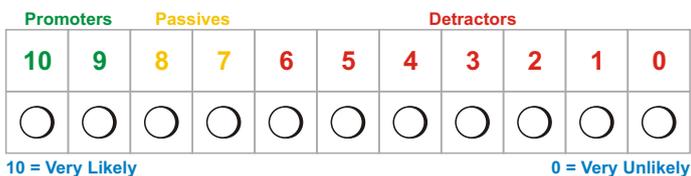
Main Reasons Why Customers Leave

68% – Poor attitude and indifference by the service provider. Indifference means that customers feel they are not appreciated or treated well by your organisation.
14% – Dissatisfaction with product or service.
9% – Lured by competitors.
9% – Other reasons.

The quality of the organisation's customer care can be determined by a measure called the Net Promoter Score (NPS). NPS is a very robust measure of customer satisfaction; it indicates whether an organisation's customers would recommend the organisation to other customers.

The NPS can be obtained by asking the ultimate question:

On a scale of 0 – 10, how likely is it that you would recommend or promote our organisation to other customers?

Promoters		Passives		Detractors						
10	9	8	7	6	5	4	3	2	1	0
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

10 = Very Likely   0 = Very Unlikely

NPS = % of Promoters (9s and 10s) **- % of Detractors** (0 through 6)

To calculate your organisation's NPS, you take the percentage of customers that are Promoters and subtract the percentage of customers that are Detractors.

The principle behind the NPS is that every organisation's customers can be divided into three categories, as follows: Promoters, Passives, and Detractors. By asking the simple question above; you can track the three groups of customers and obtain a clear measure of your organisation's customer care performance through your customers' eyes. Customers respond on a scale of 0 - 10 and are categorized as follows:

Promoters (Score 9 - 10): These are loyal customers who are not only satisfied with your organisation's products or services, but are delighted about your organisation's customer care performance. This group of customers keeps buying and refers others, invariably fuelling growth.

Passives (Score 7 - 8): These are somewhat satisfied customers; they are however not necessarily delighted about your organisation's customer care performance. This group of customers is vulnerable to enticement by your competitors.

Detractors (Score 0 - 6): These are very unhappy customers who will damage your brand through negative word-of-mouth. This group of customers is ready to defect to your competitors, or remains customers merely because your organisation either does not have competitors or the competitors are just as bad as your organisation.

The accounting data does not fully describe the circumstances of the business. The Financial Manager should look beyond financial statements to obtain valuable insight into developing or existing organisational problems. The fact that a business is profitable now does not necessarily mean that it is healthy. Quality management distinguishes between good and bad profits. Bad profits are realised whilst customers are unhappy; this is not sustainable. The NPS measure helps the organisation gain valuable insight into how the number one stakeholder in the organisation feels - the customer.

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About the Author

Monde Mekute is currently the Executive Manager: Quality Assurance at Carl Zeiss Optronics (Pty) Ltd based in Pretoria. Monde has a BSc degree in Chemistry & Applied Chemistry from the University of Cape Town (UCT), a degree in Quality Management, and other qualifications in Business Management. He possesses extensive quality assurance & quality control work experience in the manufacturing environment. He has worked for major organisations in the pharmaceutical, petrochemical, pulp & paper, technology, and aviation industries.

Quality management is his profession and business excellence is his passion. He is an Associate Member of the South African Quality Institute (SAQI).

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Governing Organisations on Equal Basis: Non-profit organisations (NPOs)

Article issued by CGF Research Institute

There's a proverb that says, "what's sauce for the goose is sauce for the gander" - this expression can also generally be interpreted to mean "what's good for the male is also good for the female." Whilst this proverb refers largely to gender-equity based issues, it could also apply to the manner in which corporate governance principles should be equally applied in the context of business, no matter its type, size or value.

Rather interestingly, since the launch of the King Report on Governance for South Africa 2009 (King III) which became effective on 01 March 2010, a Cape Town based non-profit group has claimed growing support on behalf of a Civil Society Working Group -- called the Working Group -- to disregard King III for non-profit organisations (NPOs).

The Working Group suggests the King III provisions are impractical for NPOs and by their own admission "recognised the need for South African civil society to formulate and adopt its own distinct code, rather than (to) be regulated by government or corporate sector codes". To this end, they have now introduced their own draft code, which notably is devoid of many of the King III provisions and is known as the Independent Code.

Whilst the intentions of the Working Group may have been good; and even with their claim that they have "consulted hundreds of NPOs across the country", one wonders why yet another code for governance is necessary when a far more thorough set of governance guidelines have been assembled by the local and international subject matter experts originally convened for the King III Commission and the writing of King III.

Expectedly, a lot of confusion has set in with the introduction of the Working Group's new draft Code. One needs to seriously consider the implications such a Code will have upon corporate businesses, including other major donors of NPO funding when a new set of governance codes is introduced, which according to the Working Group is completely different to the recommendations of King III, and very much reduced of its criteria as compared to King III.

Besides the fact that some of the larger NPOs asset base is as large as those of private and even listed companies, corporate funders and donors of NPOs need assurance that their donated funds are being used responsibly, and that strict measures of governance are in place for accountability purposes. By suggesting a 'lesser' governance code as introduced by the Working Group is better suited for all NGOs -- who are estimated to tally around 150 000 organisations -- is surely a fast way to discourage future funding and is frankly speaking, irresponsible and unfair to NGOs in the long run.

Once reading the Independent Code which consists of 18 pages, one quickly realizes that this rather 'relaxed' Code -- unlike King III which provides more structured detail and numerous Practice Notes as recommendations for implementation -- can become open for abuse by unscrupulous NPO officers who "self regulate" and then claim to be practicing good governance. Of course a person could argue the same about King III; however King III's audit, risk, combined assurance and external evaluation recommendations (as examples of additional measures not detailed in the Independent Code) certainly do make it a lot more difficult to circumvent King III as compared to the Independent Code.

Besides the confusion this Code may still cause amongst many of the larger NPOs, its authors have clearly 'watered

down' many of the provisions found in King III, and they have also failed to address many critical issues of governance. This in turn could prove disastrous, particularly where larger NPOs control vast sums of money and / or have large or complex organisations. To illustrate this point further, the Independent Code lacks any form of practical guidance particularly where the NPO has no members, and the Board has -- in reality -- no up-line accountability for its poor, or non-performance besides reporting to itself. The Independent Code also misses the point of Board accountability, stating that the "Board must hold management accountable for the practical implementation of (its) their responsibilities". The Independent Code further states, "while affirming the critical responsibility of the Board, there are other stakeholders of an NPO who also bear a share of the responsibility, and they too must play their part in ensuring that effective governance takes place."

Following this thinking, two critical questions arise:

i.   to whom is the NPO Board ultimately accountable, particularly when there are no members, and

ii.   surely all accountability rests with the Board, and the Board only (as is stated in King III but remiss in the Independent Code).

As for good governance, in general terms the Board is fully accountable for the organisation's risk and risk management including the financial affairs of the organisation, whilst management are responsible to implement programmes that mitigate these risks. Whilst management are held responsible for not mitigating risk, the ultimate accountability must always rest with the Board and the Board remains answerable to the company or other entity constituting the NPO. When these risks are not fully factored by the Board, the Board members must be held to account by their shareholders derivatively and / or the members in the case of the NPO. Where a NPO does not have members, it would be advisable for the NPO to approach its major donors and request of them to become members so that accountability exists between the Board and the selected members of the NPO. The liabilities attached to poor governance must be the same for both private organisations as well as for NPOs.

Whilst the Independent Code was conceived by what appears to be a very small group of people, it may have been more useful to rather apply King III -- based on its 'flexible apply or explain' basis -- than to write a new code for NPOs. In so doing, not only would this approach provide a common and more complete view of good governance principles across all organisations, it would also be far simpler if all organisations, including NPOs, were singing from the same hymn sheet. Of course, whilst not wishing to detract from the importance of a singular standard of good governance principles as found in King III, it is important to note that King III is an aspirational code, and if NPOs were finding themselves constrained by a lack of resources to adopt its recommendations, they could phase in the basic principles which are applicable to them, over a period of time.

To suggest that the King III Code, hailed as an international benchmark for corporate governance across all organisations, does not adequately reflect the values and ethos of the NPO sector, and that the King III principles are completely impractical and unaffordable for many non-profits, makes no sense at all.

The intention of King III was to allow any organisation to adopt its governance principles as they deem necessary, and where deviations occur, organisations need to explain the reasons thereof. To create a new code of governance for NPOs is certainly not necessary and if this were in any circumstance to be commended, then surely a whole new set of governance codes should also be considered for state owned entities, sole proprietorships, close corporations and other forms of informal business entities. There needs to be one set of governance standards to which all entities must abide. Of course, with King III being flexible, they can be scalable to meet the specific requirements of smaller or less structured businesses. At the end of the day we are dealing with a value system, and this value system must have equal benefit as well as equal penalties when those in control of organisations flout the accepted parameters, especially where people and money are concerned.

Quality in Schools

a regular column by Dr Richard Hayward

As most of our readers are parents themselves, we have asked SAQI's education editor Richard Hayward (rpdhayward@yahoo.com), a retired headmaster and published author to give us some words of wisdom on how to get quality principles instilled in young people.

What happened at 22:50 on Sunday, 5 August 2012?

Were you watching it happen on TV? The scene was the London Olympics athletics track. The best sprinters in the world were under starter's orders for the final of the 100 metre race. In less than ten seconds Usain Bolt showed the world that he was still the fastest man on the planet.

Many compliments have been made about the organisation of the Olympics: the Opening and Closing Ceremonies, the elegance of the Victory Ceremonies and much more. Then, of course, there was superb time management. Events started and finished on time.

All quality organisations pay attention to time management. The excellent school views punctuality as very important. If an athletics meeting is meant to start at 14:00, that's when it starts. If a parent has an interview with a teacher, it starts at the agreed-on time. Such schools insist on punctuality from both the children and the teachers.

King Louis XVIII of France stated that, 'Punctuality is the politeness of kings.' To be late except for an unforeseen emergency is simply bad manners. In our society there are powerful individuals who mistakenly believe that it's a statement of importance to arrive late for a function. Yes, it's a statement but one of arrogance. It shows disregard for those who were on time. It also reflects poor time management.

The time demands on a child on any school day can be huge. Besides the usual classroom lessons, there are the sport and cultural activities. There's homework too. Then the children themselves would like their own 'chill-out' time to do their own thing or simply nothing!

Those children who are able to do all that has to be done have time management skills. They've taught themselves or been helped by parents and teachers to use time well. They're focused children who achieve their goals.

If there's a child that runs frantically from one deadline to another and every now and then falters, there can be unpleasant consequences. The child will be disciplined for lateness for school activities as well as for submitting work after deadline dates. Frequent lateness can sour relationships with classmates and teachers. That child needs to be helped to use time well.

Time management is a skill that adds quality and happiness to school days. It's also invaluable for a life of quality.

Richard Hayward does programmes on behalf of SAQI. For more details of the Total Quality Education (TQE): the five pillars of Quality schools workshops, please contact Richard (011-888-3262; rpdhayward@yahoo.com). Poor schools are sponsored for hosting workshops.

SAQI Training Programme for 2012

All courses offered by the South African Quality Institute are presented in association with other course providers and are available to all organisations including SMMEs and corporates. SAQI can assist with the training of a company's workforce and all training packages can be run in-house at cheaper rates. A special 10% discount applies to SAQI members. **All prices include VAT**. For more information or to register contact Vanessa du Toit at (012) 349 5006 or **vanessa@saqi.co.za**

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B12	ISO 14000 overview	1	R2,150.00				
B14	Integrated Management Requirements	3	R4,250.00				
B16	Internal Quality Auditing	3	R4,400.00		17-19		
B20	Organisational QMS Lead Auditor	5	R9,980.00	10-14			
B24	How to write procedures	2	R3,740.00			15-16	
B34	Statistical Process Control	5	R9,980.00	17-21			
B38	Development of QMS	5	R9.980.00		8-12		
B41	Introduction to Quality Control	1	R2,150.00	7			
B48	ISO 9001 Requirements Workshop	3	R4,250.00		3-5		
B49	SHEQ Internal Auditing	3	R4,250.00	4-6			
B58	Customer Satisfaction and Excellence	2	R3,740.00	11-12			
B64	Introduction to Quality Techniques	3	R4,250.00				
B65	SAQI Certificate in Quality	10	R18,320.00			5-9	3-7
B66	Problem Solving and Decision Making	3	R5,200.00				

SAQI also offer the following courses on an inhouse basis for 10 or more delegates. Please contact vanessa@saqi.co.za for a quote.

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